

Practice Improvement Protocol 3

Autistic Spectrum Disorders



**Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services**

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I. Service Population

Diagnosis: Autistic Spectrum Disorders (299.0)

II. Desired Outcome

A. Change in Target Signs and Symptoms

1. Remission or substantial reduction of self stimulating behaviors, tantrums, self-injury or bizarre and odd behaviors such as:
 - Twirling;
 - Flapping;
 - Inappropriate attachment to inanimate objects;
 - Obsessive interests; or
 - Unusual and persistent preoccupations.
2. Decrease in motor restlessness, agitation;
3. Improvement in physiologic functioning (sleep, appetite, energy);
4. Decrease in intensity, frequency, and assessed level of risk of behaviors dangerous to self and or others.

B. Functional Improvement

Behavioral health services should be provided to facilitate behavior that improves language, attention, socialization and communication.

Includes behavioral support for educational and habilitative services, speech and language therapy, social skills training and other developmental support services.

C. Exacerbating factors and signs/symptoms education

The individual will demonstrate age and functionally appropriate understanding of the role of substance abuse, stress and medication non-compliance for his/her condition.

The individual and caregiver and/or family will be able to verbalize the signs/symptoms of relapse or recurrence of behavioral problems.

D. Functional Support

The individual will be able to maintain behavior appropriate to his/her developmental/cognitive level in home and community setting; including work, school and other public settings.

E. Environment Support

Behavioral health providers, medical providers and other involved agencies will be collaborating effectively in appropriate interventions to systematically coordinate behavioral health services with other involved agencies and care-givers in order to promote development in the least restrictive manner.

The individual's primary social supports (parents, siblings, caregivers, spouses, significant others, employers, etc.) will demonstrate knowledge of and appropriate response to the individual's prominent psychiatric symptoms; physiologic functioning; exacerbating or relapse factors and relapse symptoms; dangerousness to self and/or others.

III. Major Differential Diagnoses and/or Comorbid Conditions

Pervasive Developmental Disorder Not	Hearing impairment
Otherwise Specified (NOS)	Communication Disorder
Asperger's Disorder	Mental retardation, moderate/severe
Expressive language delay/disorder	ADHD
Receptive language delay/disorder	Rett's Disorder
Schizophrenia with childhood onset	Bipolar Disorder
Selective mutism	

These are to be considered as differential or co-morbid diagnoses concurrent with or prior to the initial diagnosis, and upon relapse, exacerbation, and/or failure to improve

after treatment/intervention of up to six months.

IV. Recommended Practice and Coordination

A. BHS (Behavioral Health Services)

1. A range of Autistic Spectrum Disorders exists with varying levels of function in different domains such as cognitive, emotional and social. A significant number of individuals are impaired in multiple domains and will function at a level of mental retardation.
2. Autistic Spectrum Disorders frequently present as a “social skills deficit syndrome,” with many areas of functioning intact. Although high functioning individuals may be quite articulate, emotional responsivity may need to be taught because it is not intuitive.
3. The overall treatment strategy should emphasize collaborating with the school, community and natural supports, and other providers in teaching social, communication and cognitive skills to the individual and effective behavior shaping techniques to parents, to be used both during and after termination of therapy. Techniques should emphasize positive reinforcement for appropriate behavior and acknowledgment and reward of the individual’s ability to establish age-appropriate autonomy to the extent possible. Antecedents to behavioral disruptions, agitation or self-injury should be identified and minimized. Social-pragmatic teaching can also be helpful in enhancing the individual’s repertoire of social and communicative behaviors.
4. Individual therapy can be very helpful to address feelings of isolation and to improve social adjustment for individuals with verbal functioning. Play therapy or expressive therapies may assist those with impairments in this domain.
5. For school aged individuals (through age 22), a release of information should be obtained from the legal guardian to communicate with preschool, workplace or school staff to document behavior that is affecting academic performance; this communication should occur at the beginning of treatment and at prescribed intervals thereafter. To as great an extent as possible, school staff should be

included in the individual's treatment and in the implementation of the behavior-shaping program.

6. In collaboration with the family and other involved professionals, and with consideration of all areas described in Section II, Desired Outcomes, a list of target symptoms and treatment goals should be developed.
7. A screening tool such as the Vineland Adaptive Scale and the (CBCL) may be given to parents and teachers at the initiation. The Test of Nonverbal Intelligence (TONI) together with the Vineland is recommended if IQ testing must be performed, especially between the ages of four and eight. If standard verbal IQ tests are used after the age of eight, the psychologist should be familiar with the array of language deficits associated with these disorders. IQ testing prior to the age of eight is not recommended; an IQ prematurely diagnosed as low because of language deficits can lead to inappropriate institutionalization and lack of encouragement to and by parents as the individual develops.
8. Ongoing coordination of care is essential and is the responsibility of the primary behavioral health professional, if one has been assigned. Typical parties involved include the DDD support coordinator, primary care provider, psychiatrist, OT/PT, speech, language, habilitative specialists, school or vocational personnel and family members.
9. Individuals with Autistic Spectrum Disorders may have intermittent anxiety, affective, psychotic or traumatic stress disorders. Clinicians must carefully consider co-morbid disorders, which are frequently associated with the autistic syndrome. In some cases, it may be important to distinguish whether the syndrome is due to or separate from the Autistic Spectrum Disorder. For example, although hyperactivity is common in individuals with an Autistic Spectrum Disorder, response to stimulants may be adverse. SSRI medications and beta-blockers may be more efficacious.
10. Medications can be helpful for target symptoms and behaviors. The psychiatrists must choose from all available psychoactive medications will best

improve functioning with minimal side effects. Knowing the individual with an Autistic Spectrum Disorder may not be able to self-report improvement or problems due to the medication, the clinician should always include collaterals or collateral information in the evaluation. As such, primary caregivers, family members, community supports and when appropriate, child/family team members, should be included in the assessment and ongoing pharmacological treatment. Serotonin modulating medications (atypical antipsychotics and SSRI antidepressants) can be especially helpful with self-stimulatory, compulsive or stereotyped behaviors.

11. Family strength can be reinforced through family support services, health promotion and respite.
12. In addition to services provided through behavioral health and DDD, there are a number of alternative and ancillary treatment modalities available to families, and it is essential for the clinician to be knowledgeable about them. These include sensory integration techniques, music therapy, language-behavioral therapies (such as Applied Behavioral Analysis, "Lovaas," "Pace," "TEACCH," and others), vitamin therapies, immuno modulators, naturopathic, homeopathic, chiropractic treatments, treatment with the pancreatic hormone secretin and auditory integration training. The clinician who is knowledgeable and informed about these and other approaches can help each family make the best choice for themselves.
13. For the moderate to severely impaired, treatment goals are the same. Methodology may focus more on medical treatment and family support, with less emphasis on psychosocial treatments of the individual.

A. Medical Health Services

1. All relevant information, including the initial assessments and treatment plan, must be communicated to the primary care provider (PCP) to ensure coordination of services.
2. Information relative to the individual's medical condition and treatment should

be obtained from the PCP.

3. There is an estimated 25% risk of developing seizures in adolescence (age 12 and up). In collaboration with the primary care provider, referral to specialists and diagnostic EEG, MRI and chromosome screening (for disorders such as tuberous sclerosis and neurofibromatosis) should be considered.

B. Collateral Resources/Ancillary Services

1. Protection & Advocacy

While remaining sensitive to the incidence of self-injurious behavior, reports to Child/Adult Protective Services (CPS or APS) must be made when there is suspicion of neglect or abuse, including medical or emotional. For open CPS or APS cases, the protective services case plan must be coordinated with the behavioral health services. CPS case managers must be invited to all behavioral health services staffings and reviews.

2. Division of Developmental Disabilities

If the individual is not yet enrolled in DDD and mental retardation, autism, or a qualifying seizure disorder is diagnosed, referral to DDD should be made for eligibility determination. If DDD is providing services related to the developmental disability, such services must be coordinated with the behavioral health services. DDD support coordinators must be invited to all behavioral health services staffings and reviews. All relevant information, including the initial assessments and treatment plan, must be communicated to DDD to ensure coordination of services. Per the ADHS/DES/DDD IGA and Operational Procedure Manual, for DDD/ALTCS individuals, the DDD support coordinator is the lead case manager.

3. Probation, Parole, Correctional Facility, or Other Civil/Criminal Court

If court, probation and parole officers are involved with the individual, conditions of probation, parole and related services should be coordinated with

the behavioral health services.

4. AHCCCS/ALTCS

Referral to ALTCS should be made for eligibility determination if there is a long-term physical disability indicating a need for ALTCS services. If ALTCS is providing services, such services should be coordinated with the behavioral health services.

5. Education

The parent/legal guardian will be advised to request the school district's cooperation. This will include the school's participation in the initial and ongoing evaluation and interventions. The parent may also request the school to provide a comprehensive evaluation to determine special education eligibility, IQ testing, or an accommodation assessment. The behavioral health professional should participate in the development of the Individual Education Plan (IEP) to assist the school in maintaining the individual in the least restrictive individual educational setting, and to support the primary caregiver through the IEP process.

6. Vocational Rehabilitation

Vocational training may be available through the school to individuals who are under the age of 16 and designated as emotionally handicapped (EH). For persons 16 and over, referral to VR services should be considered and services coordinated, if appropriate.

V. References

The medical literature on therapeutics for Autistic Spectrum Disorders is rich and growing. The clinician is well advised to keep abreast of the most recent developments in the field.

Further reference materials include:

BOOKS & CHAPTERS ON AUTISM

Autistic Disorder And Other Pervasive Developmental Disorders. Leventhal, Crofts and Cook, in: Psychiatry Vol. I, 1997, W.B. Saunders Co., Tasman, Kay, Lieberman

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Behavioral Intervention for Young Children with Autism: A Manual for Parents and Professionals, C. Maurice, et al Austin: Pro-Ed, 1996

Thinking in Pictures: And Other Reports of My Life with Autism, T. Grandin Doubleday, 1995

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